APPENDIX C

SAMPLE LETTERS

FOR A PRINTABLE VERSION OF ALL FORMS, PLEASE GO TO THE OPEHI'S WEBSITE AT:

http://personnel.ky.gov/hlthins/adminifo.htm

SAMPLE

USE YOUR AGENCY LETTERHEAD

DATE

Employee Name
Employee Address
City, State and Zip code

Dear *(Employee Name)*:

This letter is to inform you that because you failed to return your health insurance application by the appropriate date, you have been automatically assigned to *(name of health insurance plan)* , *(type of plan, i.e., HMO, POS,or PPO,)*, Option *(A)* , Single level of coverage. Your coverage will become effective on (*insert effective date*).

Enclosed is your copy of the health insurance application showing you have been automatically assigned. You should keep this copy to carry with you for proof of coverage until you receive your I.D. card from the health insurance company. Because you have been automatically assigned, you will not be eligible to direct any money left from your State Contribution into the Commonwealth Choice Health Care Spending Account.

If you have any questions, please feel free to contact me.

Sincerely,

(Your Name)
Insurance Coordinator
(Your phone number)

Enclosure

Dependent Add Form

Employee Name	Company Number
Social Security Number - -	Qualifying Event Date / /

To be eligible to ADD a dependent to your Public Employee Health Insurance Program, you must certify that the dependent has experienced the Qualifying Event (QE) check below. The QE's listed below are the only QE's that allow you to ADD your dependent. To be considered an eligible dependent, the dependent must be one of the following:

- The employee's legal spouse
- An unmarried child, stepchild, adopted child, or foster child, under the age of 24 who is dependent on the employee for more than 50% of his/her maintenance and support. And, the dependent must live with the employee in a parent-child relationship.
- An unmarried grandchild under the age of 24 of whom you hold legal guardianship and are/will be able to claim him/her on your federal income tax return.

The above dependents may be added using this letter for the following QE's:

- ❑ Birth;
- ❑ Legal guardianship, court ordered guardianship, administrative or court order, adoption;
- ❑ Marriage;
- ❑ Divorce/Legal Separation/Annulment;
- ❑ Spouse/dependent loses other coverage;
- ❑ Spouse has different open enrollment period; or
- ❑ Waived coverage; has now lost other coverage.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material or material misrepresentation contained herein may be used to void the contract.

Dependent's Name	Dependent's Social Security #
Dependent's Name	Dependent's Social Security #
Dependent's Name	Dependent's Social Security #
Employee's Signature	Date

COMMONWEALTH OF KENTUCKY, COUNTY OF_____
Subscribed and sworn to before me, a Notary Public, by:

_____this_____day of _____, 20___.

Notary Public_____

My Commission expires:_____

Dependent DROP Form

Employee Name	Company Number
Social Security Number - -	Qualifying Event Date / /

To be eligible to DROP a dependent from your Public Employee Health Insurance Program, you must certify that the dependent has experienced the Qualifying Event (QE) checked below. You also must agree that you are not under any court order to cover the dependent on your health insurance plan. These are the only QE's that allow you to drop your dependent.

If this applies, please complete the information below and have this letter notarized by a Notary Public.

- ❑ Ineligible Dependent (marriage, moved out of home, age 24);
- ❑ Medical Card;
- ❑ Medicare;
- ❑ Spouse/dependent obtain coverage under another employers plan;
- ❑ Divorce/Legal Separation/Annulment;
- ❑ Death of Dependent, including spouse; or
- ❑ Spouse had different Open Enrollment period.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material or material misrepresentation or material omission contained herein may be used to void the contract.

Dependent's Name	Dependent's Social Security #
Dependent's Name	Dependent's Social Security #
Dependent's Name	Dependent's Social Security #
Employee's Signature	Date

COMMONWEALTH OF KENTUCKY, COUNTY OF_____
Subscribed and sworn to before me, a Notary Public, by:

_____this_____day of _____, 20___.

Notary Public_____

My Commission expires:_____

Re-Establishing Dependent Eligibility Form

Employee Name: _____ Company Number: _____

Social Security Number: __ __ __ - __ __ - __ __ __ __ Qualifying Event Date: ___/___/___

To be eligible to ***ADD*** a dependent to your public employee health insurance plan, you must certify that he/she is an eligible dependent according to the guidelines of the plan. To be considered an ***eligible*** dependent, the dependent must meet all of the following (Please mark all that apply):

- Unmarried* child, stepchild, adopted child, foster child or grandchild
- Under the age of 24
- Dependent on the employee for more than 50% of his/her maintenance and support
- Lives in the employee's household in a parent-child relationship

If all of the above apply, please complete the information below and have this letter notarized.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material or material misrepresentation or material omission contained herein may be used to void the contract.

_____ ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Dependent's Name Dependent's Social Security #

_____ ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Dependent's Name Dependent's Social Security #

_____ _____
EMPLOYEE'S SIGNATURE DATE

COMMONWEALTH OF KENTUCKY: COUNTY OF _____
Subscribed and sworn to before me, a Notary Public, by

_____, this _____ day of _____, 20_____.

SAMPLE
USE YOUR AGENCY LETTERHEAD

M E M O R A N D U M

TO: *(Employee)*

FROM: Insurance Coordinator

DATE:

SUBJECT: TEFRA for Active Employees Age 65 and Over

This letter is to inform an employee, nearing the age of 65, of his/her health insurance options upon becoming eligible for Medicare. As a result of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Medicare now supplements employer group health insurance plans. This means that if an employee elects coverage under the state sponsored health insurance plan, Medicare will pay benefits on a secondary basis.

MEDICARE

You will receive information regarding Medicare enrollment approximately three months prior to your 65th birthday. *If you are eligible* for Medicare Part A, the coverage will be free and enrollment will be automatic. Medicare Part B is **not** free and enrollment is **not** automatic. You are encouraged to contact your local Social Security office to determine your eligibility for these programs.

PUBLIC EMPLOYEE HEALTH INSURANCE PROGRAM

Your Medicare eligibility or enrollment (Part A & Part B) does not affect your eligibility to continue coverage with the Public Employee Health Insurance Program as long as you continue to meet the eligibility requirements as an "employee". State sponsored plans offer the same health care coverage (under like conditions) to all active employees, regardless of age.

EMPLOYEE OPTIONS

Since you will be eligible to participate in Medicare and the Public Employees Health Insurance Program, you should compare the cost of each, the benefits of each and make your decisions based upon your needs.

You may choose Medicare Parts A & B as your only source of coverage and waive your state sponsored health insurance. There is a monthly premium for

Medicare Part B. Some of the items not covered by Medicare at the present time include prescription drugs, eyeglasses, dentures, hearing aids, routine physical checkups and related tests.

You may choose not to enroll in Medicare Part B and continue in the state sponsored health insurance plan. The health insurance carrier will coordinate benefits with Medicare. You may delay enrollment in Medicare Part B until a later date, however, you will need to contact your local Social Security office regarding the Special Enrollment requirements, including dates.

Please contact your local Social Security office and/or check the Centers for Medicare and Medicaid Services website* to obtain all the information necessary to make your decisions.

*http://cms.hhs.gov/default.asp?fromhcfadotgov=true

SAMPLE

USE YOUR AGENCY LETTERHEAD

MEMORANDUM

TO: *(Employee on Family Leave)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved Family Leave

This letter is to inform you of your health insurance responsibilities as an employee on family leave. As an employee on Family Leave, the state will continue to make the **employer** contributions for your health insurance and Commonwealth Choice (Flexible Spending Account), if applicable. It is your responsibility to make timely payments of any employee contribution amounts that had previously been deducted for health insurance or Commonwealth Choice.

Health Insurance
While on Family Leave, two conditions must be met in order to qualify for the employer contribution for health insurance. The first is you must maintain the level of coverage that was in effect before going on leave. Secondly, you must pay the employee contribution, if applicable. To continue your health insurance you must submit a check made payable to your insurance carrier, in the amount of $_____ (employee contribution).

Commonwealth Choice *(if applicable)*
If you are enrolled in Commonwealth Choice and contribute your own money (employee contribution), you may submit a check in the amount of $_____ made payable to ***FRINGE BENEFITS MANAGEMENT COMPANY***. If you choose not to continue the employee contribution, the annual contribution amount will be adjusted accordingly. If you wish to resume your employee contribution when you return from Family Leave, you must complete a new enrollment form.

The payments for health insurance and Commonwealth Choice should be submitted to the following address by the 10th of each month. **Please include your Social Security number on each check.**

_____

_____

_____

Miscellaneous Insurances (payroll deducted)
All other insurances and deductions made from your paycheck will cease unless timely payments are made. You should contact the company directly. Our records indicate that you have the following additional insurance and/or deductions:

(List Payroll Deductions)

If you exhaust your Family Leave time before you are able to return to work, you will be sent a COBRA notification letter, which allows you to continue your health insurance totally at your own expense. Should you opt to not continue under COBRA, you will be restored to your previous level of coverage immediately upon your return to work.

If you have any questions, please feel free to contact me at _____.

M E M O R A N D U M

To: *(Employee on Military Leave)*

From: *(Insurance Coordinator)*

Date:

Re: Employees Called to Active Military Service

A number of questions have arisen due to the call-up of Public Employees for active duty in the United States Armed Forces. The Office of Public Employee Health Insurance (OPEHI) wants to make you aware of a new and important policy concerning health insurance benefits for these employees and remind you of some choices the employee will need to make. All employees called to active military service are eligible for health benefits through the United States Government. Details on this coverage should be obtained through appropriate military personnel. Their dependents may also be eligible for military health insurance coverage; however, confirmation should be obtained from military personnel prior to making any changes affecting dependents.

The policy for all Public Employees called up for active service from September 11, 2001, forward will be as follows:

If the employee has single coverage through the Commonwealth Group and is using paid leave or has not been removed from the payroll via formal action:

1. The employee may "Stop" their health insurance coverage on the last day of the month in which he/she activates with armed services. This option will allow the employee to "Start" their health insurance coverage immediately upon return to public employment. This Stop and Start process will in no way negatively impact an employee with regard to pre-existing conditions application to claims for service under the OPEHI policy.
2. If the employee elects to maintain their current level of health insurance coverage, as well as maintain military health care coverage, the employee must insure that the applicable premiums are available via payroll deduction or are received by their Insurance Coordinator no later than the 15th day of the month preceding the coverage month.

If the employee has coverage for dependents through the Commonwealth Group:

3. The employee may elect to maintain their current level of health insurance coverage and insure that the applicable premiums are

available via payroll deduction or are received by their Insurance Coordinator no later than the 15th day of the month preceding the coverage month.

4. The employee may “Stop” their health insurance coverage on the last day of the month in which he/she activates with armed services. This option will allow the employee to “Start” their health insurance upon return to public employment. This Stop and Start process will in no way negatively impact an employee with regard to pre-existing conditions application to claims for service under the OPEHI policy.

Employees called to active duty must elect one of the preceding options for their health insurance during the time they are activated. The only option that may be affected by the minimum or maximum length of activation is dependent coverage and the employee is responsible for that verification. All premiums due upon return from active duty will be determined by the date of return to active employment.

Military activation is a Qualifying Event to cease a health Flexible Spending Account. However it is not a qualifying event to start or make changes to a Health Flexible Spending Account.

Please contact the OPEHI Member Services Branch with questions surrounding this issue. Please direct all payroll related questions to the appropriate payroll manager.

SAMPLE

USE YOUR AGENCY LETTERHEAD

M E M O R A N D U M

TO: ***(Employee on LWOP)***

FROM: ***(Insurance Coordinator)***

DATE:

SUBJECT: Guidelines for Benefits While on Approved LWOP

As an employee on Leave Without Pay (LWOP), you are eligible to continue your health insurance, Commonwealth Choice contribution, and any miscellaneous insurance(s) that you are having payroll deducted at your own expense. You must contact *(Insurance Coordinator)* to make arrangements to continue your benefits coverage.

Health Insurance

To continue your group health insurance coverage you must pay the premiums to your agency or through COBRA. After you have been on LWOP for 30 or more working days, you will receive a COBRA Notification Letter.

A. If you are on LWOP and you have pay during the month the leave starts, you will be eligible for the employer contribution for health insurance for the following month. However, if the pay you receive is not sufficient to cover the employee's portion of the premium, you will need to submit a check for the amount due.

   If you are on leave without pay and you do not have pay during a month, you will not be eligible for the employer contribution for health insurance for the following month. In this case, you must pay the total premium amount (**employer and employee portion, if applicable**) to continue your health insurance coverage.

Any portion of a premium due by you must be submitted to the Insurance Coordinator by the **20th of the month**. The check must be payable to the appropriate **Insurance Carrier** and have your **social security number listed on the check**. The Insurance Coordinator will forward the payment to the appropriate Insurance Carrier.

NOTE: If you fail to submit appropriate premium payments due within the specified deadline, the Insurance Carrier may cancel the **ENTIRE POLICY**.

B. If you will be on LWOP for 30 or more working days, you must continue your coverage through COBRA. You will need to fill out the COBRA election form, new application and submit your COBRA premium(s), made payable to the Insurance Carrier, to your Insurance Coordinator, as instructed in the COBRA notification material. Your Insurance Coordinator will be responsible for mailing these COBRA materials to you after you have been on LWOP for 30 days or more.

Health Flexible Spending Account

To continue your participation in the Health Expense FSA you must submit a check to your Insurance Coordinator, in the amount of $_____ **made payable to *(FSA Third Party Administrator)*.** If you do not continue this contribution while on LWOP, you will **not** be eligible to participate in the program for the remainder of the plan year once you return to work.

Miscellaneous Insurances (payroll deducted)

To continue your miscellaneous insurances that you are having payroll deducted, send payments directly to the insuring company. Our records indicate that you have the following additional insurance and/or deductions:

(List Payroll Deductions)

When you return to work after being on LWOP you must work more than half of the workdays in the month you return to be eligible to receive the employer contribution for health insurance for the following month. If you do not work more than half of the workdays in the month you return, the first day of the second month rule applies regarding your effective date of your health insurance.

When you return from LWOP your length of absence may affect your health insurance. If you do not elect to continue health insurance while on LWOP, and have more than a 63-day break in coverage, you will be subject to pre-existing conditions when your coverage resumes.

When you return to work after being on LWOP you will not be eligible to make any changes to the health insurance coverage in which you were enrolled prior to the LWOP unless one of the following has occurred:

- You experience a Qualifying Event and you apply for an appropriate change within thirty (30) days of that Qualifying Event

except for the birth of a newborn baby, which would require you to apply within sixty (60) days.

- You return in a new plan year or after the open enrollment period and you apply for a coverage change no later than thirty (30) days after your return.

The Insurance Coordinator must provide the necessary applications upon return.

- The coverage in which you were enrolled in prior to the beginning of the LWOP is not available upon your return. You will have no more than thirty (30) days after your return to apply for an appropriate change. If you do not request the change, you will be subject to the auto-assignment guidelines.

The Insurance Coordinator must provide the necessary applications upon return.

Should you have any questions, you may contact me at _____.

FLEXIBLE BENEFITS CANCELLATION FORM

Unless a Flexible Benefits Cancellation Form is signed, employees paying for insurance will AUTOMATICALLY be placed on Flexible Benefits (paying with pre-tax dollars. Serious consideration should be given to the Flexible Benefits plan, and if you do not want it, complete and sign this form.

Social Security Number	Name – Last	First	MI
- -			

Home Address – Number/Street	City	State	Zip Code

County	Home Telephone ( )	Employment Date
	Work Telephone ( )	- -

Name of State Agency	Company Number

I hereby elect to cancel my participation in the Flexible Benefits Plan. I understand that I will not have another opportunity to participate until a subsequent Open Enrollment Period. I also understand that signing this form does not cancel my health insurance coverage, only my opportunity to participate in the pre-tax method of payment.

Employee Signature

Date

Effective Date:

FLEXIBLE BENEFITS/PREMIUM CONVERSION
RE-ENROLLMENT FORM

Employees who cancelled out of Flexible Benefits/Premium Conversion will continue to pay for health insurance premiums in a post-tax status unless a Flexible Benefits Re-Enrollment Form in signed and delivered to their payroll officer.

This form is not valid unless sent to your payroll officer first.

Social Security Number	Name – Last	First	MI
- -			

Home Address – Number/Street	City	State	Zip Code

County	Home Telephone ( )	Employment Date
	Work Telephone ( )	- -

Name of State Agency	Company Number

I hereby elect to alter my Flexible Benefits/Premium Conversion standing from post-tax to pre-tax status. I have read and understand the conditions and limitations involved with participation in the Flexible Benefits/Premium Conversion Plan.

Employee Signature _____ Date _____

Effective Date: